OMB No. 0925-0195
Expiration Date 2/28/98

Department of Health and Human Services
Public Health Service

Small Business Technology Transfer Program

Phase I Grant Application

Follow instructions carefully.

Leave blank — for PHS use only.		
Type	Activity	Number
Review Group		Formerly
Council Board *(Month, year)*		Date Received

1. TITLE OF APPLICATION *(Do not exceed 56 typewriter spaces)*

2. SOLICITATION NO.

3. PRINCIPAL INVESTIGATOR ☐ New Investigator

3a. NAME *(Last, first, middle)*	3b. DEGREE(S)	3c. SOCIAL SECURITY NO.
3d. POSITION TITLE	3e. MAILING ADDRESS *(Street, city, state, zip code)*	
3f. TELEPHONE AND FAX *(Area code, number, and extension)* TEL: FAX:	BITNET/INTERNET Address:	

4. HUMAN SUBJECTS ☐ NO ☐ YES
4a. If "yes," Exemption no. **or** ☐
IRB approval date ☐ Full IRB **or** ☐ Expedited Review
4b. Assurance of compliance no.

5. VERTEBRATE ANIMALS ☐ NO ☐ YES
5a. If "Yes," IACUC approval date
5b. Animal welfare assurance no.

6. DATES OF PROJECT PERIOD
From: *Through:*

7. COSTS REQUESTED
7a. Direct Costs $
7b. Total Costs $

8. PERFORMANCE SITES *(Organizations and addresses)*

9. APPLICANT ORGANIZATION *(Name and address of applicant small business concern)*

10. ENTITY IDENTIFICATION NUMBER | Congressional District

11. SMALL BUSINESS CERTIFICATION
☐ Small Business Concern ☐ Women-owned
☐ Socially and Economically Disadvantaged

12. NOTICE OF PROPRIETARY INFORMATION: The information identified by asterisks(*) on pages _____ of this application constitutes trade secrets or information that is commercial or financial and confidential or privileged. It is furnished to the Government in confidence with the understanding that such information shall be used or disclosed only for evaluation of this application, provided that, if a grant is awarded as a result of or in connection with the submission of this application, the Government shall have the right to use or disclose the information herein to the extent provided by law. This restriction does not limit the Government's right to use the information if it is obtained without restriction from another source.

13. DISCLOSURE PERMISSION STATEMENT: If this application does not result in an award, is the Government permitted to disclose the title only of your proposed project, and the name, address, and telephone number of the official signing for the applicant organization, to organizations that may be interested in contacting you for further information or possible investment? ☐ YES ☐ NO

14. OFFICIAL SIGNING FOR APPLICANT ORGANIZATION
Name:
Title:
Address:
Telephone:
FAX:
BITNET/INTERNET Address:

15. PRINCIPAL INVESTIGATOR ASSURANCE: I certify that the statements herein are true, complete, and accurate to the best of my knowledge. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. I agree to accept responsibility for the scientific conduct of the project and to provide the required progress reports if a grant is awarded as a result of this application.

SIGNATURE OF PERSON NAMED IN 3a *(In ink. "Per" signature not acceptable.)* | DATE

16. APPLICANT ORGANIZATION CERTIFICATION AND ACCEPTANCE: I certify that the statements herein are true, complete, and accurate to the best of my knowledge, and accept the obligation to comply with Public Health Service terms and conditions if a grant is awarded as a result of this application. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties.

SIGNATURE OF PERSON NAMED IN 14 *(In ink. "Per" signature not acceptable.)* | DATE

Abstract of Research Plan

NAME, ADDRESS, AND TELEPHONE NUMBER OF APPLICANT ORGANIZATION

YEAR FIRM FOUNDED	NO. OF EMPLOYEES *(include all affiliates)*

TITLE OF APPLICATION

KEY PERSONNEL ENGAGED ON PROJECT

NAME	ORGANIZATION	ROLE ON PROJECT

ABSTRACT OF RESEARCH PLAN: State the application's broad, long-term objectives and specific aims, making reference to the health-relatedness of the project. Describe concisely the research design and methods for achieving these goals and discuss the potential of the research for technological innovation. Avoid summaries of past accomplishments and the use of the first person. This abstract is meant to serve as a succinct and accurate description of the proposed work when separated from the application. If the application is funded, this description, as is, will become public information. ***Therefore, do not include proprietary or confidential information***. DO NOT EXCEED 200 WORDS.

Provide key words (8 maximum) to identify the research or technology.

Provide a brief summary of the potential commercial applications of the research.

Budget of Applicant Organization for Phase I—Direct Costs Only

FROM | TO

PERSONNEL *(Applicant organization only)*		Type Appt. *(months)*	% Effort on Project	Institutional Base Salary	**DOLLAR AMOUNT REQUESTED** *(omit cents)*		
NAME	Role on Project				Salary Requested	Fringe Benefits	**TOTALS**
SUBTOTALS →							

CONSULTANT COSTS		
EQUIPMENT *(Itemize)*		
SUPPLIES *(Itemize by category)*		
TRAVEL		
PATIENT CARE COSTS	Inpatient	
	Outpatient	
CONTRACTUAL COSTS		
OTHER EXPENSES *(Itemize by category)*		
TOTAL DIRECT COSTS *(Also enter on Face Page, Item 7a)* →		$
FIXED FEE REQUESTED		$

OTHER SUPPORT *(see instructions)* ☐ NO ☐ YES

Principal Investigator *(Last, first, middle):* _____

Budget of Research Institution for Phase I

FROM: | TO:

NAME AND ADDRESS OF RESEARCH INSTITUTION

PERSONNEL		Type Appt. *(months)*	% Effort on Project	Institutional Base Salary	**DOLLAR AMOUNT REQUESTED** *(omit cents)*		
NAME	Role on Project				Salary Requested	Fringe Benefits	**TOTALS**
SUBTOTALS →							

CONSULTANT COSTS		
EQUIPMENT *(Itemize)*		
SUPPLIES *(Itemize by category)*		
TRAVEL		
PATIENT CARE COSTS	Inpatient	
	Outpatient	
CONTRACTUAL COSTS		
OTHER EXPENSES *(Itemize by category)*		
TOTAL DIRECT COSTS		$
INDIRECT COSTS *(show calculation)*		
TOTAL COSTS *(Also enter as "Contractual Costs" on Budget of Applicant Organization—form page 3)*		$

CERTIFICATION OF RESEARCH INSTITUTION PARTICIPATION

Through the signature below of the duly authorized representative of the research institution on this budget page, and by way of the signature of the official signing for applicant organization (small business concern) on the Face Page of the application, the small business concern and the research institution certify *jointly* that: (1) the proposed STTR project will be conducted jointly by the small business concern and the research institution in which not less than 40 percent of the work will be performed by the small business concern and not less than 30 percent of the work will be performed by the research institution ("cooperative research and development"); (2) the proposed STTR project is a cooperative research or research and development effort to be conducted jointly by the small business concern and the research institution in which not less than 40 percent of the work will be performed by the small business concern and not less than 30 percent of the work will be performed by the research institution ("performance of research and analytical work"); and (3) regardless of the proportion of the proposed project to be performed by each party, the small business concern will be the primary party that will exercise management direction and control of the performance of the project. If the research institution is a contractor-operated federally funded research and development center, the duly authorized representative of the contractor-operated federally funded research and development center certifies, *additionally*, that it: (4) is free from organizational conflicts of interests relative to the STTR program; (5) did not use privileged information gained through work performed for an STTR agency or private access to STTR agency personnel in the development of this STTR grant application; and (6) used outside peer review, as appropriate, to evaluate the proposed project and its performance therein.

SIGNATURE of duly authorized representative	Printed Name	Title	Date

Budget Justification

Using continuation pages if necessary, describe the specific functions of the personnel and consultants. Read the instructions and justify costs accordingly.

Resources

FACILITIES: Specify the facilities to be used for the conduct of the proposed research. Indicate their capacities, pertinent capabilities, relative proximity, and extent of availability to the project. Include laboratory, clinical, animal, computer, and office facilities at the applicant small business concern and any other performance site listed on the FACE PAGE. Identify support services such as secretarial, machine shop, electronics shop, and the extent to which they will be available to the project. Use continuation page(s) if necessary.

MAJOR EQUIPMENT: List the most important equipment items already available for this project, noting the location and pertinent capabilities of each.

Checklist

This is the required last page of the application.

TYPE OF APPLICATION *(Check appropriate box[es].)*

☐ NEW application. *(This application is being submitted to the Public Health Service for the first time.)*

☐ REVISION of previously-submitted application number _____
(This application replaces a prior unfunded version of a new application.)

☐ CHANGE of Principal Investigator *(if applicable)*
Name of former Principal Investigator _____

1. ASSURANCES/CERTIFICATIONS

The assurances/certifications set forth below are made and verified by the signature of the OFFICIAL SIGNING FOR APPLICANT ORGANIZATION (small business concern) on the FACE PAGE of the application. Descriptions of individual assurances/certifications are found in application instructions under "**Checklist**." If unable to certify compliance with any item, provide an explanation and place it after this page.

• Human Subjects; • Vertebrate Animals; • Debarment and Suspension; • Drug-Free Workplace; • Delinquent Federal Debt; • Research Misconduct; • Civil Rights (Form HHS 690); • Handicapped Individuals (Form HHS 690); • Age Discrimination (Form HHS 690).

2. PROGRAM INCOME *(See discussion in application instructions under "**Checklist**.")*

All applications must indicate *(Yes or No)* whether program income is anticipated during the period for which grant support is requested.

☐ No ☐ Yes *(If "Yes," use the format below to reflect the amount and source(s) of anticipated program income.)*

Budget Period	Anticipated Amount	Source(s)

3. INDIRECT COSTS *(See discussion in application instructions under "**Checklist**.")*

Insert the rate, if known. If the applicant organization does not have a currently negotiated rate with the Department of Health and Human Services (DHHS) or another Federal agency, it must estimate the amount of indirect costs allocable (applicable) to the proposed Phase I project. That amount should be inserted in the space provided below. The applicant organization should also be prepared to furnish financial documentation to support the estimated amount, if requested by the Public Health Service. An applicant organization may elect to waive indirect costs if it so desires.

☐ DHHS agreement, dated: _____ . _____ % salary and wages or _____ % Total Direct Costs.

☐ No DHHS agreement, but rate established with _____, dated: _____

☐ Rate negotiation pending with the National Institutes of Health.

☐ Indirect costs allocable (applicable) to this Phase I project are estimated to be $ _____

☐ No indirect costs requested.

4. SMOKE-FREE WORKPLACE

Does your organization currently provide a smoke-free workplace and/or promote the non-use of tobacco products or have plans to do so?

☐ Yes ☐ No *(The response to this question has no impact on the review or funding of this application.)*